Medications / Nutritional Supplements Usage Form

Use the back of this form if you need more space.

Name _____ Date _____

Please list **all** prescription medications you are **currently taking**:

Name of Medication	Diagnosis/Reason for taking it	How long you have been taking it

Please list **all** prescription medications you are **no longer taking** but have taken in the past 3 years:

Name of Medication	Diagnosis/Reason for taking it	How long you had been taking it

Please list **all** over-the-counter / recreational drugs you are **currently taking**:

Product Name	Symptom/Reason for taking it	How often you take it

Please list **all** nutritional supplements you are **currently taking** (vitamins, herbs, homeopathics, etc.):

Product Name	Manufacturer	Why you take it	Amount taken daily	How long taken

Check the following items which apply to you and indicate the amount used:

☐ Alcohol _____	☐ Soy products _____	☐ Antacids _____
☐ Coffee _____	☐ Chocolate / Carob _____	☐ Laxatives _____
☐ Non-Herbal tea _____	☐ Candy and Sweets _____	☐ Water: tap _____
☐ Herbal teas _____	☐ Artificial sweeteners _____	☐ Water: filtered _____
☐ Carbonated drinks _____	☐ Diet sodas _____	☐ Tobacco products_____